# OPTIMA HEALTH PLAN

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions:** ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

**Drug Requested:** **Osphena**® (ospemifene)

***DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.***

**Drug Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis**: _____ ***ICD Code, if applicable***: _____

***CLINICAL CRITERIA*: *ALL boxes must be checked to qualify or authorization process will be delayed. Chart notes MUST be attached to this request.***

- ❑ Patient is a post-menopausal woman diagnosed with moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause

**AND**

- ❑ Patient has trial and failure of ***30 days of therapy*** with ***TWO (2)*** of the following medications:

| | | |
|---|---|---|
| ❑ Premarin vaginal cream | ❑ Prempro tablets | ❑ generic Alora patches |
| ❑ Premarin tablets | ❑ Estradiol tablets | ❑ generic Climara patches |
| ❑ Premphase tablets | | |

***Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.***

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

**DEA OR NPI #:** _____

***Approved by Pharmacy and Therapeutics Committee**: 10/15/2015
**REVISED/UPDATED:** ~~10/23/2015~~; ~~12/22/2015~~; ~~12/19/2016~~; **8/15/2017**